

# Patient Registration / Health History

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ I prefer to be called \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Child \_\_\_\_\_

Home Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Mobile # \_\_\_\_\_

Work # \_\_\_\_\_ Email \_\_\_\_\_

Whom may we thank for referring you to our clinic? \_\_\_\_\_

## In the event of emergency, who should we contact?

Name \_\_\_\_\_ Phone# \_\_\_\_\_

## METHOD OF PAYMENT (Please check all that apply)

I do not have dental insurance and I agree to pay for any and all treatment either:

Prior to treatment  Day services are provided

I have dental insurance and would like to have this office file insurance claims for me. I understand that all insurance co-pay estimates are due the day of service.

## Primary Dental Insurance:

Insurance company name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured's date of birth \_\_\_\_\_ Insured's SS# \_\_\_\_\_ Insured's employer \_\_\_\_\_

## Secondary Dental Insurance:

Insurance company name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured's date of birth \_\_\_\_\_ Insured's SS# \_\_\_\_\_ Insured's employer \_\_\_\_\_

## If the above patient is under the age of 18, Person Responsible for Account

Often the person responsible for the children's dental bills is unclear. In our office, the parent who brings the child in and requests treatment is the one responsible for all fees incurred.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Mobile # \_\_\_\_\_

Work # \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_